Section 1: Introduction

In December 1993 the Centers for Disease Control and Prevention (CDC) issued a program guidance requiring that the 65 health departments that receive federal HIV prevention funds establish HIV prevention community planning groups. The guidance was issued, in part, as a response to a general consensus that publicly funded HIV prevention programs needed to improve in their ability to target HIV prevention interventions to those most at risk for infection.

In 1994, the District of Columbia created the HIV Prevention Community Planning Group (CPG) to help plan locally relevant HIV prevention programs. The first official meeting was held on June 1, 1994.

The CPG set out to develop the District's first HIV Prevention Plan, which was completed in October 3, 1994. Approval of the plan marked the first milestone of collaboration between public health agencies and community representatives that continues to this day.

The goal of community planning is to improve the effectiveness of HIV prevention programs by strengthening the scientific base of prevention intervention, their relevance to the community, and the risk-based focus of prevention interventions. Together, representatives of affected populations, epidemiologists, behavioral and social scientists, HIV/AIDS prevention service providers, health department staff, and others analyze the course of the epidemic in the District, assess and prioritize HIV prevention needs, identify HIV prevention interventions to meet those needs, and develop HIV prevention plans that are directly responsive to the epidemic. The HIV/AIDS Administration (HAA) uses the information on prioritized prevention needs in its annual application for federal HIV prevention funds from the CDC.

The primary purpose of the District of Columbia HIV Prevention Plan is to identify the HIV prevention needs of District residents and to prioritize populations at highest risk for HIV infection, as well as the most effective HIV prevention strategies and interventions for those populations. The plan also sets a course for the future to prevent new HIV infections. It is the product of the concerted efforts of individuals affected and infected by HIV, prevention providers, government agencies, researchers, and advocates.

The HIV Prevention Plan for 2000-2002 was developed between March and August 1999 following guidelines from the CDC, and approved in September 1999. Sections 4, 5 and 9 were updated in September 2000, and Sections 9 and 10 were updated in September 2001.

The plan is divided into the following sections:

Section 2: Population Specific Prevention Needs: This assessment describes the HIV prevention needs of 22 populations that are defined by gender, race/ethnicity, risk behavior, age and other variables, and identifies some of the HIV prevention interventions that have proved effective for those populations.

Section 3: Resource Inventory and Gap Analysis: The Resource Inventory describes existing HIV prevention programs by target populations as identified by the CPG in 1998. The gap analysis is the result of a comparison between the prevention needs identified in the Needs Assessment and the resource inventory.

Section 4: Potential Strategies and Interventions: This section describes the potential strategies and interventions that can be used to prevent new HIV infections.

Section 5: Prioritization of Populations and Interventions: Using the information in the Epidemiologic Profile, Population-Specific Prevention Needs, Resource Inventory, Gap Analysis, and the description of potential strategies and interventions, the CPG prioritizes the prevention needs of at-risk populations and the interventions that are most appropriate for each of those populations.

Section 6: Coordination and Linkages: This section describes how governmental and non-governmental agencies will coordinate to provide HIV prevention services and programs within the District.

Section 7: Future Directions: This section describes short- and long-term goals and objectives for HIV prevention in the District.

Section 8: Capacity Building Technical Assistance: This section describes the plans to carry out a study to determine the capacity-building technical assistance needs of HIV prevention providers – including HAA and community based organizations funded by HAA – in the areas of program planning, implementation, and evaluation.

Section 9: Evaluation: This section describes HAA's plans to evaluate major program activities, interventions and services, including the effectiveness of the community planning process and the implementation of the HIV Prevention Plan.

Section 10: Epidemiologic Profile: The HIV/AIDS epidemiologic profile describes the epidemic in District, and includes data from a variety of sources, including reported AIDS cases, demographic data, and surrogate markers for HIV risk behaviors, e.g., sexually transmitted disease. The profile provides a narrative explanation of all data, including a description of populations at risk for HIV infection.

The Prevention Plan was written for four principal audiences:

- The HIV Prevention Community Planning Committee, which will use this Plan as a basis for moving forward with the further development of prevention planning.
- The Administration for HIV/AIDS, which is responsible for implementing the recommendations contained in the Plan.
- The Centers for Disease Control and Prevention, which will consider the quality of this Plan when funding amounts are considered.
- HIV Prevention Providers in the District of Columbia, who will look to this Plan for guidance in developing, implementing and evaluating prevention programs.

Definition Of HIV Prevention Community Planning

Excerpted from the CDC Guidance For HIV Prevention Community Planning

HIV prevention community planning is an ongoing, comprehensive planning process that is intended to improve the effectiveness of health departments' HIV prevention programs by strengthening the scientific basis, community relevance, and population- or risk-based focus of prevention interventions. HIV prevention community planning is:

1. evidence-based (i.e., based on HIV/AIDS and other epidemiologic data, including STD and behavioral surveillance data; qualitative data; ongoing program experience; program evaluation; a comprehensive needs assessment and resource inventory process, and other local data), and
2. incorporates the views and perspectives of groups at risk for HIV infection for whom the programs are intended, as well as providers of HIV prevention services.

Together, representatives of affected populations, epidemiologists, behavioral and social scientists, HIV/AIDS prevention service providers, health department staff, and others analyze the course of the epidemic in their jurisdiction, assess and prioritize HIV prevention needs, identify HIV prevention interventions to meet those needs, and develop HIV prevention plans that are directly responsive to the epidemics in their jurisdictions.

Prioritizing HIV prevention needs is a critical part of program planning. Community planning group members are expected to follow a logical, evidence-based process in order to determine the highest priority, population-specific prevention needs in their jurisdiction. These prioritized prevention needs are particularly important to the health department in allocating prevention dollars. HIV prevention needs identified in the HIV prevention plan are then operationalized in the health department's application to CDC for federal HIV prevention funds.

CDC monitors progress in community planning through the following five core objectives:

1. Fostering the openness and participatory nature of the community planning process.
2. Ensuring that the community planning group reflects the diversity of the epidemic in the jurisdiction, and that expertise in epidemiology, behavioral/social science, health planning, and evaluation are included in the process.
3. Ensuring that priority HIV prevention needs are determined based on an epidemiologic profile and a needs assessment.
4. Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost and cost effectiveness, theory, and community norms and values.
5. Fostering strong, logical linkages between the community planning process, application for funding, and allocation of CDC HIV prevention resources.

The overall goal of HIV prevention community planning is to have in place a HIV prevention plan that is current, evidence based, adaptable as new information becomes available, tailored to the specific needs and resources of each jurisdiction, and widely distributed in an effort to provide a roadmap for prevention that can be used by all prevention providers in the jurisdiction.

All grantees are required to adhere to the following principles:

1. HIV prevention community planning reflects an open, candid, and participatory process, in which differences in cultural and ethnic background, perspective, and experience are4 essential and valued.
2. HIV prevention community planning is characterized by shared priority setting between health departments administering and awarding HIV prevention funds and the communities for whom the prevention services are intended.

3. Priority setting accomplished through a community planning process produces programs that are responsive to high priority, community-validated needs within defined populations. Persons at risk for HIV infection and persons with HIV infection play a key role in identifying prevention needs not adequately met by existing programs and in planning for needed services that are culturally appropriate. HIV prevention programs developed with input from affected communities are likely to be successful in garnering the necessary public support for effective implementation and in preventing the transmission of HIV infection.
4. HIV prevention community planning is characterized by inclusion, representation, and parity. These are fundamental tenets of HIV prevention community planning. Inclusion is defined as the assurance that the views, perspectives, and needs of all affected communities are included and involved in a meaningful manner in the community planning process. This is the assurance that the community planning process is inclusive of all the needed perspectives. Representation is the assurance that those who are representing a specific community truly reflect that community's values, norms, and behaviors. This is the assurance that those representatives who are included in the process are truly able to represent their community. However, these representatives must also be able to participate as group members in objectively weighing the overall priority prevention needs of the jurisdiction. Parity is the condition whereby all members of the HIV prevention community planning group are provided opportunities for orientation and skills building to participate in the planning process and to have equal voice in voting and other decision-making activities. This is ensuring that those representatives who are included in the process can participate equally in the decision-making process.
5. Representation on a community planning group includes:

    - persons who reflect the characteristics of the current and projected epidemic in that jurisdiction (as documented by the epidemiologic profile) in terms of age, gender, race/ethnicity, socioeconomic status, geographic and metropolitan statistical area (MSA)-size distribution (urban and rural residence), and risk for HIV infection. Members should articulate for, and have expertise in understanding and addressing, the specific HIV prevention needs of the populations they represent. At the same time, they must be able to participate as group members in objectively weighing the overall5 priority prevention needs of the jurisdiction.
    - staff of state and local health departments, including the HIV prevention and STD treatment programs; staff of state and local education agencies; and staff of other relevant governmental agencies (e.g., substance abuse, mental health, corrections). experts in epidemiology, behavioral and social sciences, program evaluation, and health planning.
    - Representatives of key non-governmental and governmental organizations providing HIV prevention and related services (e.g., STD, TB, substance abuse prevention and treatment, mental health services, homeless shelters, HIV care and social services) to persons with or at risk for HIV infection.
    - representatives of key non-governmental organizations relevant to, but who may not necessarily provide, HIV prevention services (e.g., representatives of business, labor, and faith communities).

6. The HIV prevention community planning process attempts to accommodate a reasonable number of representatives without becoming so large that it cannot effectively function. To assure needed input without becoming too large to function, HIV prevention community planning group(s) seek additional avenues for obtaining input on community HIV prevention needs and priorities, such as holding well-publicized public meetings, conducting focus groups, and convening ad hoc panels. This is especially important for obtaining input relevant to marginalized populations or to scientific or agency representation that may be difficult to recruit and retain as members of the planning group.
7. Nominations for membership are solicited through an open process and candidates are selected, based on criteria that has been established by the health department and the community planning group. The nomination and selection of new community planning group members occurs in a timely manner to avoid vacant slots or disruptions in planning. In addition, the recruitment process for membership in the HIV prevention community planning process is proactive to ensure that socio-economically marginalized groups, and groups that are underserved by existing HIV prevention programs, are represented.
8. All members of the HIV prevention community planning group(s) are offered a thorough orientation, as soon as possible after appointment. The orientation includes:
    - understanding the roles and responsibilities outlined in this document,
    - understanding the specific policies, procedures, and ground rules for deliberations and decision-making, resolving disputes, and avoiding conflict of interests that are consistent with the principles of this guidance and are developed with input from all parties. These policies and procedures address:
    - process for making decisions within the planning group (vote, consensus, etc.),
    - conflict(s) of interest for members of the planning group(s),
    - disputes within and among planning group(s),
    - differences between the planning group(s) and the health department in the prioritization and implementation of programs/services, and a process for resolving these disputes in a timely manner when they occur. understanding the history of the community planning group and its decisions to date, and
    - understanding HIV prevention interventions and comprehensive prevention programs.
9. Health departments assure that HIV prevention community planning group(s) have access to current information related to HIV prevention and analyses of the information, including potential implications for HIV prevention in the jurisdiction. Sources of information include evaluations of program activities, local program experience, programmatic research, the best available science, and other sources, especially as it relates to the at-risk population groups within a given community and the priority needs identified in the comprehensive plan.
10. Identification, interpretation, and prioritization of HIV prevention needs reflect the epidemiologic profile, needs assessment, resource inventory, and culturally relevant and

linguistically appropriate information obtained from the communities to be served, particularly persons with or at risk for HIV infection.

11. Priority setting for specific HIV prevention strategies and interventions is based on specific criteria outlined in this document and each criterion should be formally considered by the HIV prevention community planning group(s) during priority-setting deliberations.
12. The HIV prevention community planning process produces a HIV prevention plan, jointly developed by the health department and the HIV prevention community planning group(s), which includes specific, high priority HIV prevention strategies and interventions targeted to defined populations. Each health department's application for CDC funds addresses the plan's high priority elements that can be met by HIV prevention cooperative agreement funds.
13. The allocation of CDC-awarded resources reflects, to a reasonable degree, the epidemic in a jurisdiction. When this is not the case, there should be a convincing explanation for discrepancies, i.e., the use of state or other funds.
14. Because the plan is comprehensive, it is distributed widely as a resource to guide programmatic activities and resources outside of those supported with CDC federal HIV prevention funds.
15. The HIV prevention community planning process is evaluated to ensure that it is meeting the core objectives of community planning.

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